CodingTrainer.com

September 1, 2010

Maryland Medical Record Fees

The adjusted rates for medical record copying are as follows: A preparation fee of $22.18 (with the preparation fee not being charged to patients exercising their right of access in accordance with HIPAA), plus a copying charge of $.73 per page; plus the actual cost of shipping and handling.

What is a Medical Record. Think you know?

A medical record in Maryland is described as follows:

§4–101.

In this subtitle, "confidential record" means any record, report, statement, note, or other information that:
(1) Is assembled or obtained for research or study by:(i) The Drug Abuse Administration;(ii) The AIDS Administration; or (iii) The Secretary; and (2) Names or otherwise identifies any person.

This means essentially anything you put in the file can constitute part of the medical record. This includes prescription, notes from patients, clinical notes ,note from other physicians, consults ,eyeglass, prescriptions, ,EKGs, and all other test reports.

§4–102.

(a) (1) Each confidential record shall remain in the custody and control of:(i) The Drug Abuse Administration, if that Administration assembled or obtained the confidential record; (ii) The AIDS Administration, if that Administration assembled or obtained the confidential record; or (iii) The Secretary or an agent or employee of the Secretary, if the Secretary assembled or obtained the confidential record.
(2) The confidential record may be used only for the research and study for which it was assembled or obtained.
(3) A person may not disclose any confidential record to any person who is not engaged in the research or study project.
(b) This section does not apply to or restrict the use or publication of any statistics, information, or other material that summarizes or refers to confidential records in the aggregate, without disclosing the identity of any person who is the subject of the confidential record.

This is pretty obvious in that you can't redisclose information in one research project to the team on any other research project. Team members may share the appropriate information on a research project they are involved in.

§4–103.

A person who violates any provision of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000.

Next time: More of Maryland's Medical Record Law explained. You can read Maryland's Medical Record Law on our webpage at the following address : http://www.codingtrainer.com/mmrlaw.pdf

Transmittal 79 From DHMH Puts Physicians in Bind

The Department of Health and Mental Hygiene has issued transmittal 79 which declares that Maryland Medical Assistance will no longer pay as secondary to Medicare in most physician related cases.

This will have a significant impact on physician offices as the balance owed after Medicare pays

must be written off. You cannot charge a Medical Assistance patient for balances owed.

The final 20% of the Medicare allowed amount must be written off.

Maryland was actually the last state to implement this policy after the federal government allowed it some 5 years ago. It was only put into place (August 1, 2010) after Maryland had a new computer system installed in January. It took until late July to reprogram the computer.

DHMH officials took the irregular step of passing the new policy at the Board of Public Works meeting in Annapolis in the fall. Not many attend the Board of Public Works meeting so it surprised the medical community when the transmittal came out. Med Chi, the states medical society didn't have it on it's radar screen and neither did the hospital association.

You can read Transmittal 79 on our website at http://www.codingtrainer.com/transmittal79.pdf

Medicare Question

Question: When a physician sees a patient and bills an inpatient E/M and the patient's status is later changed by the hospital to outpatient, why does this occur? And how does Medicare review a "place of service"?

What are the influencing factors in this scenario?

- A UR committee consisting of two or more practitioners must carry out the UR function. At least two members of a hospital's UR committee must be doctors of medicine or osteopathy.
- Other members may be any of the other types of practitioners specified in regulation.
- The policy for changing a patient's status using Condition Code 44 requires the determination to change a patient's status be made by the UR committee with physician concurrence.
- The hospital may not change a patient's status from inpatient to outpatient without UR committee involvement.
- The conditions for the use of Condition Code 44 require physician concurrence with the UR committee decision.
    - One physician member of the UR committee may make the determination for the committee that the inpatient admission is not medically necessary.
        - This physician member of the UR committee must be a different person from the concurring physician for Condition Code 44 use, who is the physician responsible for the care of the patient.
- When the UR committee determines the admission is not medically necessary based on their Inpatient criteria, the committee must give written notification, no later than 2 days after the determination, to the hospital, the patient, and the practitioner responsible for the care of the patient.
- The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
    - The hospital has not submitted a claim to Medicare for the inpatient admission;
    - A physician concurs with the utilization review committee's decision; and
    - The physician's concurrence is documented in the patient's medical record.

How Does Medicare Review the Record for Level of Care?

- Medicare contracts with Quality Improvement Organizations (QIOs) to evaluate medical records for level-of-care appropriateness.
- The QIO reviews documentation to determine whether there is consistency between the physician's order, the physician's intent, the services provided, the medical necessity of the services, and the patient type billed by the facility.
- Some QIOs use InterQual criteria as an objective tool, but must also take into account the physician's decision-making process.
    - McKesson's Interqual criteria are used by Medicare and most hospitals to determine whether a patient qualifies x

for observation or an inpatient admission.
- The criteria tools can be purchased in electronic or paper formats.
- They compare documentation present in the patient's record to criteria in the screening tool.

It is always prudent to verify the patient's status with the Facility. Also, if the attending physician disagreed with the Facility's change of status, the attending physician should appeal this decision with the Facility.

Question: Is it okay to code for both CPR (CPT 92950) and Critical Care (99291) by the same physician?

Answer: Possibly. This will depend on the provider's documentation. Typically the performance (running) of CPR will take about 30 minutes with some cases with a lesser time frame and others greater. CPT code 99291 is based on unit/floor time with patient and is defined as requiring a minimum of 30 minutes in order to report one unit of critical care. When the documentation fails to identify critical care time is separate or in addition to the performance of the CPR, then only one service/procedure may be billed for the 30 minute time frame: either CPR [Typically valued higher than one unit of critical care] or Critical care. It is important for providers to clearly document in such cases to allow for accurate coding.

Question: What is the correct code for the use of Versajet™ to debride a wound?

Answer: According to CPT Assistant June 2010, the correct code for this procedure would be from range 97597-97598. Versajet™ uses pressurized sterile fluid to debride a wound. Usage of Versajet™ is considered a non-excisional debridement technique. However, when the physician performs actual surgical debridement with the assistance of Versajet™ CPT is silent on how to properly report. In our learned opinion should a physician perform excisional debridement with the assistance of the Versajet™ and the patient is anesthetized (not Moderate Sedation), then the correct code series for this would be 11040-11044.

Administrative Day Revenue Codes

There have been ongoing issues with the proper submission and payment of claims billed for administrative day revenue codes.

After extensive testing, changes are being moved into production tomorrow (8/26) that will enable our system to appropriately edit claims billed for administrative days based on the current administrative day addendum billing instructions.

To avoid future denials, please assure that claims billed for administrative days are billed in accordance to current UB04 Hospital Billing Instructions (Addendum Instructions - Administrative Days), which can be found on-line at the website below:

http://www.dhmh.state.md.us/html/npi_instructions.htm

Coding Mini-Quiz: Integumentary

1. When coding for a simple and intermediate wound repairs:

   A. Code only for the intermediate repair
   B. Code both repairs and use modifier 51
   C. Code both repairs and use modifier 59
   D. Code a complex repair

2. Skin closure of a tendon repair is considered:

   A. Never included in the tendon repair
   B. Always included in the tendon repair
   C. Included when either a simple or an intermediate closure
   D. None of the above

3. Tissue adhesive used to close a skin wound:

A. Report as part of an E/M service
B. Requires the use of modifier 52 with CPT repair codes 12001-13160
C. Requires the use of modifier 22 with CPT codes 12001-13160
D. Qualifies as a skin repair and may be coded as a simple repair using CPT codes 12001-12021.

4. A burn patient presents today for skin grafts. Grafted are the anterior trunk [1000 sq.cm.] and both hands [350 sq.cm.]. All areas had the eschar tissue excised. Trunk was grafted with a STSG. Hands were grafted with an epidermal graft. Grafts were all sutured in place.

   A. 15100, 15100 x9, 15155, 15156 x4
   B. 15100, 15100 x9, 15115, 15116 x3
   C. 15100, 15100 x9, 15155, 15156 x4, 15002, 15003 x9, 15004, 15005 x3
   D. 15100, 15100 x9, 15115, 15116 x3, 15002, 15003 x9, 15004, 15005 x3

5. Patient has a burned right arm. The physician placed Biobrane over the burned area and wrapped gauze over the Biobrane. How would you code this?

   A. As a skin repair
   B. As a skin graft
   C. As local treatment of a burn
   D. As part of an E/M

For answers go to:
www.codingtrainer.com/answers090110.pdf

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"Your Coding Resource"

CodingTrainer.com provides central Maryland's premier training for coders who want any of nine certifications. We have a fulltime training facility in Catonsville Maryland, one half mile from the beltway.

Our next class dates are as follows:

- Coding certification class for nine different certifications -September 7, 2010
- Certification class for CPCs or CPC-H to Become CCS-Ps – October 7, 2010
- 1th Annual Breakfast With Debbie (CPT,ICD-9) update Seminar – December 2010
- ICD-10 Seminar – January 2011
- CCS Certification course – January 2011
- Our next Saturday Class is soon.

MRR
MEDICAL REIMBURSEMENT RESOURCES

Medical Reimbursement Resources is our sister company that provides auditing and compliance services to the medical community.

MRR also provides the following services;

Compliance Audits
Baseline Audits
Medical Record Reviews
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Educational Audits
Practice Management Assessments
RAC Audits
Defense Audits

UNIVERSAL
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Universal Healthcare Placements, Inc is Central Maryland's best known administrative healthcare placement company.

They are currently looking for the following:

Neuro Coders

Traveling Coders (75% overnight travel)

Coders – All Specialties